02694

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Anne Arundel

City or town Drury - Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) all life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Drury - Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Clock Monroe Anderson

3. (b) Social Security Number None

4. Sex: Boy

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1939

8. AGE: Years 1 | Months | Days 14 | If less than one day hrs. min.

9. Birthplace Drury A A Co Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Steve Monroe Anderson
13. Birthplace Drury A A Co Md

MOTHER
14. Maiden name Thelma Bowman
15. Birthplace Drury A A Co Md

16. Informant Steve M Anderson

Address Drury, Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof March 4th 1940
(month) (day) (year)

Cemetery or crematory Drury

Location Drury Md

18. Funeral director Harrison Holt

Address Lothian Md

19. Mar 4th 1940
(Date rec'd by registrar)

H. R. Claytor
Dep Mud Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1940, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1940, to March 3 1940, and that I last saw him alive on March 3 1940.

Immediate cause of death: Broncho Pneumonia — DURATION 2/26/40

Influenza — ?

Due to Malnutrition

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F B West
M. D. or other

Address Lothian, Md. Date signed 3/4/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 7 1940
BUREAU V. S.

Dr Alexander Glen Burnie

STATE OF MARYLAND—CERTIFICATE OF DEATH

02695

1. PLACE OF DEATH (92-B)

County Anna Arundel Registration Dist. No. 21

Village or City Millersville, Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Anderson If U. S. Veteran, specify WAR None

(a) Residence: No. Indian Landing Road St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Andrew Anderson

6. DATE OF BIRTH (month, day, and year) Jan. 18, 1875

7. AGE Years 65 Months 1 Days 18 If LESS then 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) 1932

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Dover (State or country) Delaware

FATHER

13. NAME William Wheatley

14. BIRTHPLACE (city or town) Dover (State or country) Delaware

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) Unknown (State or country)

17. INFORMANT Mrs. James White (Address) Millersville, Md.

18. BURIAL, ~~CREMATION~~, OR ~~REMOVAL~~ Place Baldwin Mem. Cem. Date March 8, 1940

19. UNDERTAKER William Cook (Address) 1217 St Paul St

20. FILED March 6, 1940 Ms De Alba Dep Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March 6, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from 5/3/39, 19, to 3/6/40, 19

I last saw her alive on 3/5/40, 19; death is said to have occurred on the date stated above, at 1 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chronic Endocarditis	[illegible]
Arterio Sclerosis	

Other Contributory Causes of Importance:

Cerebral hemorrhage	1 day

Name of operation Date of

What last confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John J Maynard M.D.

(Address) Glen Burnie Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

02696

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore.

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 month, 25 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 309 West Preston Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ------

3.(a) FULL NAME: TINY BALL

3.(b) Social Security Number: Unknown

4. Sex: Female

5. Color or race: black

6.(a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -----

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years: 40 Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-2-1940 (month) (day) (year)

Cemetery or crematory: Mt Calvary.

Location: Anne Arundel Co.

18. Funeral director: Mrs Geo H. Holland

Address: 1631 Druid hill ave

19. 3/31 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30th 1940, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5th 1940, to March 30 1940, and that I last saw her alive on March 30th 1940.

Immediate cause of death: General paralysis of the insane

DURATION

Due to

Due to: Lues

Other conditions: -------

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ------

Of autopsy: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 3/30/40

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02697

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 months, 11 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 612 West Mulberry St.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: LOUIS BARNES

Dose. (1) 218-10-5617
(2) 718-07-9564

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6 (b) Name of husband or wife: ------

6(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE:

Years	Months	Days	If less than one day
49	Unknown		---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER 12. Name: Eddie Barnes

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Katie Collins

MOTHER 15. Birthplace: Maryland

18. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/12/40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Ruppert.

Address

19. March 12 1940 (Date rec'd by registrar) E. F. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7th 1940, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25th 1939, to March 7th 1940 and that I last saw h[illegible] in alive on March 7th 1940.

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to Lues	
Other conditions ------	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ------

Of autopsy ------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ------ Date of

Where did injury occur? ------
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed 3/7/40

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92nd)

02698

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Cypress Creek RD
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Severna Park Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Cypress Creek Rd.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Maurice A Blankner

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Susie B.
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 3-1873

8. AGE: Years	Months	Days	If less than one day
66	10	12	hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Retired Painter
11. Industry or business:
FATHER 12. Name: John B Blankner
13. Birthplace: Germany
MOTHER 14. Maiden name: Annie Stahl
15. Birthplace: Germany
16. Informant: Susie B. Blankner
Address: Severna Park. A-A. Co.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 19-1940 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cem.
Location: Frederick Rd.
18. Funeral director: William Cook
Address: 1217 St Paul St
19. Mar 16, 1940 (Date rec'd by registrar) M DeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 16-1940, 19, at 4 1/2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan — 1930 to date 19 —; and that I last saw him alive on Dec. 19 29.

	DURATION
Immediate cause of death: Acute Dilatation of Heart — one month from trying heart to dangerous dead.	10 months
Due to: Chronic Valvular Disease of the Heart.	10 years
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings: —
Of operations:
Of autopsy: No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James S. Billingsley M. D.
M. D. or other
Address: Glen Burnie. Md Date signed: Mar 16, 1940

RECEIVED
APR 5 1940
BUREAU V. S

02699

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13) tr

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4yr.5mo.12days

Stay in this community (yrs., or mos., or days): 4yr.5mo.12days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Chesapeake City Ward No. --
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ----------
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ----------

3. (a) FULL NAME: Margaret Brady

3. (b) Social Security Number: -------

4. Sex: Female

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years: 51 Months: Unknown Days: If less than one day: -- hrs. -- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ------

FATHER
12. Name: Andrew Waters
13. Birthplace: Maryland

MOTHER
14. Maiden name: Louise Gordon
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Mar 22/1940
(month) (day) (year)

Cemetery or crematory: Manor

Location: Near Chesapeake City, Md

18. Funeral director: H. W. Pippin

Address: Elkton, Md

19. 3/18 - 1940
(Date rec'd by registrar)

E. F. Joyce
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17th, 1940 19 ____, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5, 1935 19 March 17 19 40, and that I last saw her alive on March 17 19 40.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 2/20/40

Due to: ------

Due to: --------

Other conditions: ---------
(Include pregnancy within 3 months of death)

Major findings:

Of operations: -----

Of autopsy: --------

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: --- Injured at work? -----

23. SIGNATURE: Robert T. Whitwood
M. D. or other

Address: Crownsville, Md. Date signed: 3/18/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1940
BUREAU V. S.

Millersville -

Mr Jones.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02700

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 mos. 20 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Ferndale Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: IRENE BROOKS

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6 (b) Name of husband or wife: ~~XXX~~ John W. Brooks

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE:

Years	Months	Days	If less than one day
51	Unknown		---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: ------

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/16/40 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Balto City

18. Funeral director: Elroy Watson

Address: 1000 Brantly Ave Balto

19. 3/13 (Date rec'd by registrar) 1940 E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13th 1940, at 6:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22nd, 1939 to March 13th 1940, and that I last saw her alive on March 13th 1940.

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to Lues	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --------

Of autopsy: --------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -------- Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --------

Means of injury: ---- Injured at work? --------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 3/13/40

RECEIVED
MAR 28 1940
BUREAU V. E.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02701

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 23

Village or City Glen Burnie R.F.D. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Joseph Burley If U. S. Veteran, specify WAR

(a) Residence: No. Marley Ave Co St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	C	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Laura Burley

6. DATE OF BIRTH (month, day, and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farmer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME Unk

14. BIRTHPLACE (city or town) (State or country) Unk

MOTHER

15. MAIDEN NAME Unk

16. BIRTHPLACE (city or town) (State or country) Unk

17. INFORMANT (Address) Laura Burley Marley Md

18. BURIAL, CREMATION, OR REMOVAL Place Mt Calvary Date Mch 17, 1940

19. UNDERTAKER (Address) James A Hayes 142 W Hill St

20. FILED March 16, 1940 M S DeAlba Dep Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 14th (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 3/6/40, 19, to 3/14/40, 19

I last saw him alive on 3/14/40, 19; death is said to have occurred on the date stated above, at 6:30 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	Unknown
Chronic Endocarditis	

Other **Contributory Causes** of importance:

Cerebral Hemorrhage	8 days

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John Alexander M. D.

(Address) Glen Burnie Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

FLEMING VISNY
MAR 18 1940
BUFFALO N. Y.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a1

Registered No. 21 02702

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Robinson Station

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 3 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. Robinson Station (If rural give location)

(e) If foreign born, how long in U. S. A.? 43 years

3 (a) FULL NAME Anna Burns

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Savy Burns

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) ✓

8. AGE: Years 63 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Poultry Farm

11. Industry or business

FATHER

12. Name Noah Joseph Bosch

13. Birthplace Russia

MOTHER

14. Maiden Name Rachael Krantz

15. Birthplace Russia

16 (a) Informant Harry Bosch

(b) Address 3309 Carlisle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-40 (month) (day) (year)

(c) Cemetery or crematory Herring Run

Location Balto Co.

18 (a) Funeral director Jack Louis Jr

(b) Address 1439 E. Balto St

19 (a) 3-10-40 (Date rec'd by registrar) (b) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1940, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 6 1940, to Mar 10 1940, and that I last saw her alive on Mar 8 1940.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to	
Due to	
Other Conditions Involutional Melancholia (Include pregnancy within 3 months of death)	yrs.

Major findings:

Of operations

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Maurice F. Klawans M. D.

Address 31 Smithgate av Date signed 3/10/40

VS 3

RECEIVED
APR 6 1940
BUREAU V. S.

02703

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 yr., 4 mos. 6 days

Stay in this community (yrs., or mos., or days): Unknown

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Port Tobacco Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: U------

3. (a) FULL NAME: ELIZA BUSH

3. (b) Social Security Number: Unknown

4. Sex: Female

5. Color or race: black

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years: 63 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ------

FATHER
12. Name: Charles Jameson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Nancy Simms
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: Mch 27, 1940 (month) (day) (year)

Cemetery or crematory: St. Thomas

Location: Charles Co. Md.

18. Funeral director: Penny A. Cofer

Address: Mason Springs Md

19. Mar 26 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24th 1940, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18th 1938, to March 24 1940, and that I last saw her alive on March 24th 1940.

Immediate cause of death: Broncho pneumonia — DURATION: 3 das

Due to: This patient had a couple of cerebral hemorrhages; her last, March 15th, 1940.

Due to: [illegible]

Other conditions: Arteriosclerosis
Left hemiplegia
(Include pregnancy within 3 months of death)

Major findings:
Of operations: -----

Of autopsy: -----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 3/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

Edw. Gcarter

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02704

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 7 mos. 15 days

Stay in this community (yrs., or mos., or days) 7 mos. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Fairmount Heights Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 6014 Fairmount Hts Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward G. Carter.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	married

6 (b) Name of ~~husband or~~ wife Nancy Carter

6(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
31	?	?	____ hrs. ____ min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Teacher - Laborer

11. Industry or business —

FATHER
12. Name Saml Carter

13. Birthplace Virginia

MOTHER
14. Maiden name Florence White

15. Birthplace Virginia

16. Informant Hospital Records
Address Crownsville Md.

17. Burial Date thereof 3-6-40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D. C.

18. Funeral director Robert G. McGuire

Address 1820-9th St. N.W. Washington D.C.

19. Mar 3. 40 E. F. Joyce
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3. 1940, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1939, to March 3 1940, and that I last saw him alive on March 3. 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operation

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Date signed

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131-a)

Reg. Dist. No. 22

CERTIFICATE OF DEATH

02705

1. PLACE OF DEATH:
(a) County Aa Co
(b) City or town Jessup (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 50 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Aa Co.
(c) City or town Jessup (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ella Scott Clarke

3 (b) If veteran, name war | 3 (c) Social Security No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband ~~or wife~~ J. Beauregard Clarke

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17 1863

8. AGE: Years 76 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Howard Co Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William Scott
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna R. Stiver
15. Birthplace Maryland

16 (a) Informant Ernest Clarke
(b) Address Jessup, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 17/40 (month) (day) (year)
(c) Cemetery or crematory St Lawrence
Location Jessup Md

18 (a) Funeral director B. W. Lawrence
(b) Address 1003 W. Baltimore Street

19 (a) Mar 15-40 (Date rec'd by registrar) (b) Clara M. Haslup Registrar

MEDICAL CERTIFICATION

20. Date of death March 13 1940, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4th 1940 to Mar. 13th 1940 and that I last saw him alive on Mar. 13th 1940.

Immediate cause of death	Duration
Coronary Thrombosis	9 days
Due to Cardio-Renal-	
Due to vascular Disease	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank Shipley M. D. or other
Address Savage, Md. Date signed 3/14/40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 6 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

• 2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02706

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A.

City or town Skidmore
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Indy. County A. A.

City or town Skidmore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Bernadine Colbert.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1908

8. AGE: Years	Months	Days	If less than one day
31	9	2	hrs. min.

9. Birthplace Skidmore
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Robt. Murray
13. Birthplace A. A.

MOTHER
14. Maiden name Bessie Green
15. Birthplace A. A.

16. Informant Bessie Colbert.
Address Skidmore Ind.

17. Burial Date thereof Mar 20 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Asbury Cemetary

Location Broadbeck

18. Funeral director J. B. Johnson

Address Arcadia Ind.

19. 3 20 1940 J. J. Murphy
(Date rec'd by registrar) (Reg. Clerk)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 17 1940 at 8.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1940 to Mar 17 1940 and that I last saw h alive on March 14 1940.

Immediate cause of death Pulmonary Tuberculosis — DURATION 6 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy nnl.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice F. Klawans MD
M. D. or other

Address 31 South Calvert Date signed 3/19/40

RECEIVED
APR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-D

CERTIFICATE OF DEATH

02707

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Pasadena

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Pasadena Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Robert Henry Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Minnie Boyer Davis

6(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) March IO, I859

8. AGE:

Years	Months	Days	If less than one day
8I	-	6	hrs. min.

9. Birthplace Union County, Ohio (Town, county, and state)

10. Usual occupation Real estate agent

11. Industry or business

FATHER 12. Name John Wesley Davis

13. Birthplace Ohio

MOTHER 14. Maiden name Esther Shriver

15. Birthplace Pa.

16. Informant Roberta Everett

Address Pasadena, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Mar. I9, I940 (month) (day) (year)

Cemetery or crematory Perkins Chapel, Md.

Location near Bowie, Md.

18. Funeral director L. Kaiser

Address Laurel, Md.

19. 3-16 19 40 L. A. Brett

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March I6 19 40, at IOa M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 39 to Mar. I6 19 40

and that I last saw h im alive on March 9 19 40

Immediate cause of death Pulmonary carcinoma — DURATION I year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. A. Brett, M.D. M. D. or other

Address Pasadena Date signed 3-16-40

RECEIVED
APR 5 1940

02708

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessup, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, ~~or~~ institution: Md. H of Correction

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 124 West Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Barney Ellis

Ross. (1) NDB 514-05-7636
(2) 217-05-1550
(3) 247-01-6025

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Col'd	Single

6 (b) Name of husband or wife: XX

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 1st, 1886

8. AGE:

Years	Months	Days	If less than one day
53	9	18	9 hrs. 45 min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: XX

FATHER
12. Name: Andrew Ellis
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Records Md H of Correction XX
Address: Jessup Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 16. 1940 (month) (day) (year)

Cemetery or crematory: Cherry Hill
Location: Jessup Md.

18. Funeral director: H. L. Collins
Address: Jessup. Md

19. Mar 15 1940 (Date rec'd by registrar) Clara M Hastup Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: March 11th, 1940, at 9.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 29th 1940, to March 11th 1940, and that I last saw him alive on March 11th 1940.

Immediate cause of death: Diffuse Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Thos. H. Phillips M. D. or other

Address: Jessup, Maryland Date signed: 3-11-40

VS A15 (T) (1) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

02709

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Eastport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.

City or town Eastport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Tyler Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Edward Freeman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30 1937

8. AGE:

Years	Months	Days	If less than one day
2	10	27	hrs. min.

9. Birthplace Annapolis Md

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Samuel Freeman

13. Birthplace Annapolis Md.

MOTHER 14. Maiden name Annie E. Robinson

15. Birthplace Eastport Md

16. Informant Samuel Freeman

Address Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 29th 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John W. Taylor

Address Annapolis Md.

19. 3-29th 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28th 1940, at 1:30 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from March 28th 1940 to March 28th 1940, and that I last saw him alive on March 28th at 6:30 P.M. 1940.

	CURATION
Immediate cause of death	
Due to Scarlet Fever	1 wk 2 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Russell M.D. M. D. or other

Address Eastport Date signed 3-29th

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BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

02710

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Anne Arundel

City or town West River

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town West River Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Richard Wilson Garrett

3. (b) Social Security Number None

4. Sex M

5. Color or race C

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Emma Jane Garrett

6 (c) If alive, give age 65 yrs years

7. Birth date of deceased (mo., day, yr.) January 1 1866

8. AGE: Years 74 Months 2 Days 6 If less than one day ___ hrs. ___ min.

9. Birthplace West River (Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business Farm

FATHER 12. Name William Garrett

13. Birthplace Md

MOTHER 14. Maiden name Emma Jane Hill

15. Birthplace Md

16. Informant Mattie Garrett

Address West River

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 10, 1940 (month) (day) (year)

Cemetery or crematory Chews Cemetery

Location West River

18. Funeral director T. A. Hardesty & Son

Address Galesville, Md

19. Mar 9th 1940 (Date rec'd by registrar) W. R. Clayton Dep Mrl Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1940, at 7 A 05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 1940, to March 7 1940, and that I last saw him alive on Feb 22 1940.

Immediate cause of death Chronic Myocarditis Chronic Nephritis

Due to Arteriosclerosis

Due to

Other conditions Hypertrophy Prostate Hypertension

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. B. West M. D. or other

Address Lothian Md Date signed 3/8/40

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MAR 13 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02711

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Hotel

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: A A

City or town: Annapolis Md. Ward No. 2 (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Maryland Hotel (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Louis Dorsey Passaway

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Mary Iglehart Passaway

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec 14th 1863

8. AGE:

Years	Months	Days	If less than one day
77	3	15	____ hrs. ____ min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: Savg Bank Ret.

11. Industry or business:

FATHER — 12. Name: Louis Gardner Passaway

13. Birthplace: Annapolis Md.

MOTHER — 14. Maiden name: Marian B. Dorsey

15. Birthplace: Howard Co Md.

18. Informant: Ellen B. S. Fisher

Address: Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 31st 1940 (month) (day) (year)

Cemetery or crematory: St Anns

Location: Annapolis Md

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 3-29th (Date rec'd by registrar) 1940 J J Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 29 1940, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 27 1940, to Mar 29 1940, and that I last saw h alive on Mar 29 1940

Immediate cause of death	DURATION
Due to Lobar Pneumonia	2 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J J Murphy M. D. or other

Address: Annapolis Md Date signed 3-29-1940

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BUREAU V. S.

02712

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 7 yrs. 10 mos. 4 das.

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: HARRY M. GREEN

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	black	single

6 (b) Name of husband or wife: -------

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1913

8. AGE: Years: 27 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: George H. Green
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Amanda Rhubottom
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-3-40 (month) (day) (year)

Cemetery or crematory: White Rock Cemetery

Location: Sykesville Md.

18. Funeral director: C. Harry Weer

Address: Sykesville Md.

19. March 1 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1st 1940, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27th 1932, to March 1 1940 and that I last saw him alive on March 1st 1940.

Immediate cause of death: Pulmonary tuberculosis upper left and lower lobe right middle lobe

Due to:

Due to:

Other conditions: ------
(Include pregnancy within 3 months of death)

Major findings: -----

Of operations:

Of autopsy: ------

DURATION: ?

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work: -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 3/1/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

02713

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A-A

City or town: Annapolis Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Nu

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None.

3. (a) FULL NAME: Jacob Gross.

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife: Eugenia Gross

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1879

8. AGE: Years: 62 Months: Days: If less than one day: hrs. min.

9. Birthplace: Shady Side (Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business:

FATHER — 12. Name: Wm. Gross

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Scott

15. Birthplace: Shady Side

16. Informant: Elizabeth Gross

Address: Shady Side, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Mar 25, 1940 (month) (day) (year)

Cemetery or crematory: Broad Cemetery

Location: Shadyside, Md.

18. Funeral director: J. W. Handley & Son

Address: Galesville, Maryland

19. 3/25 1940 (Date rec'd by registrar) H. P. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1940, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1940 to March 22 1940, and that I last saw h-- alive on March 19 1940.

Immediate cause of death	DURATION
Myocarditis	
Cirrhosis	
Due to	
Due to	
Other conditions: Chronic Nephritis. Duration: one year or more. Hypertension.	

(Include pregnancy within 3 months of death) Rule R

Major findings:

Dt operations:

Dt autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Emily H. Nelson M. D. or other

Address: Lothian Date signed: 3/24/40

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APR 7 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02714

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH 93-d

County Anne Arundel Registration Dist. No. 21

Village or City Birdsville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Amos Lee Hall If U. S. Veteran, specify WAR

(a) Residence: No. Bay Ridge Ave., St., Ward. Eastport

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Wells Hall

6. DATE OF BIRTH (month, day, and year) Sept. 19, 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	6	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. retired farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. own farm

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Prince Frederick (State or country) Md.

FATHER

13. NAME unknown

14. BIRTHPLACE (city or town) unknown (State or country)

MOTHER

15. MAIDEN NAME Jane Hall

16. BIRTHPLACE (city or town) Calvert Co., Md. (State or country)

17. INFORMANT Gardiner A. Hall

(Address) 1311 West St., Annapolis

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Harmony Calvert Co. Date Mar 18 19 40

19. UNDERTAKER John M. Taylor

(Address) Annapolis Md.

20. FILED Mar. 17 19 40 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Mar. (Month) 16 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Mar. 6, 1940, to Mar. 16, 1940

I last saw him alive on Mar. 16, 1940; death is said to have occurred on the date stated above, at 2:45 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage	3-8-40
Other Contributory Causes of importance: Arteriosclerotic heart disease	?

Name of operation none Date of —

What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W. T. Fidler M. D.

(Address) Davidsonville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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APR 6 1940
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

HEALTH DEPARTMENT—CITY OF BALTIMORE

02715

CERTIFICATE OF DEATH (83-a)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Patapsco Park, Anne Arundel Co. St., Ward)

Registered No. 23 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Rosa Hamilton

If U. S. Veteran specify WAR .....

(a) Residence: No. Patapsco Park, A.A. County St., Ward. (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. Color or Race Col

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. F. Hamilton

6. DATE OF BIRTH (month, day, year) Oct 17-1895

7. AGE Years 45 Months 1 Days 6 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Richmond Va

FATHER

13. NAME Jessie Norman

14. BIRTHPLACE (city or town) (State or country) Va

MOTHER

15. MAIDEN NAME Margaret Dorage

16. BIRTHPLACE (city or town) (State or country) Va

17. INFORMANT (Address) B F Hamilton Husband Patapsco Park A.A. Co.

18. BURIAL, CREMATION, OR REMOVAL Place Mt Calvery Date Mar 26th 1940

19. UNDERTAKER (Address) Elroy O Wilson 1000 Brantley Av

20. FILED April 10, 1940 Mrs Dealba Dep. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Mar. 23, 1940

22. I HEREBY CERTIFY, That I attended deceased from Mar 15, 1940, to Mar. 23, 1940

I last saw her alive on Mar. 22, 1940. Death is said to have occurred on the date stated above, at 8 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	3/15/40

Other contributory causes of importance:

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? No Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) P. Harris M. D.

(Address) 1307 N Carlisle Av

VS 3

(Body was stored in vault until April 11-1940)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver*, etc.

In stating the industry or business avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer*, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give exact occupation, as *carpenter, painter, machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, *e. g.*, heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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MAY 4 1928
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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

02716

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Crownsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laura Virginia Hance

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Joseph J. Hance

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 5th 1863

8. AGE: Years 77 Months 2 Days 5 If less than one day hrs. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Fielder Rawlings
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Bowen
15. Birthplace Maryland

16. Informant Benj W. Hance
Address Crownsville A. A. Co Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Mar 13th 1940
(month) (day) (year)

Cemetery or crematory Asbury Chapel

Location Barstow Calvert Co Md.

18. Funeral director John M. Taylor
Address Annapolis Md.

19. 3-12th 1940 J J Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10 1940, at 6 15 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938, to March 10 1940, and that I last saw her alive on March 9 1940.

Immediate cause of death Myocarditis (Chr) + Myocardial Insufficiency

Due to Arteriosclerosis.

Due to Chr. Nephritis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION
3 years
Unknown
unknown

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Basil. M. D. or other

Address Annapolis Date signed 3-11-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1940
BUREAU V. S.

02717

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A.

City or town Skidmore
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A.

City or town Skidmore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James Westley Hayes

3. (b) Social Security Number None

4. Sex: Mare

5. Color or race: Colore

6. (a) Single, married, widowed, or divorced: Marrie

6 (b) Name of husband or wife: Della Hayes

6(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.): Feb. 5 1907

8. AGE: Years 33 | Months 1 | Days 21 | If less than one day ___ hrs. ___ min.

9. Birthplace: Skidmore
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER
12. Name: George Hays
13. Birthplace: Skidmore

MOTHER
14. Maiden name: Lillie Hays
15. Birthplace: Skidmore

16. Informant: Della Hayes
Address: Skidmore

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 29 1940 (month) (day) (year)

Cemetery or crematory: Broadneck

Location: A. A. Co

18. Funeral director: B. Johnson
Address: Annapolis

19. 3 28 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 26 1940, at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1940, to Mar. 26 1940, and that I last saw him alive on Mar. 25 1940

Immediate cause of death: Myocardial Insufficiency — DURATION 3 wks

Due to Chr. Endocarditis — Unknown

Due to Chr. Myocarditis — 3/1/40

Due to Acute Bronchitis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE J. Willis Martin M.D. M. D. or other

Address Annapolis Md. Date signed 3/29/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

02718

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Md

City or town St Margarets

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County An

City or town Rural Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. St Margarets

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Baby boy Henson

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	Col	S

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 10 40

8. AGE: Years: Still Born | Months | Days | If less than one day: hrs. min.

9. Birthplace St Margarets (Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Ellis Harris

13. Birthplace Md Co

MOTHER 14. Maiden name Mary Henson

15. Birthplace An

16. Informant Lydia Porter

Address Arnold Md

17. Buried Md (Burial, cremation, or removal. Which?) Date thereof 3 11 40 (month) (day) (year)

Cemetery or crematory

Location St Margarets

18. Funeral director Geo Henson Grandfather

Address St Margarets

19. 3 11 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 10 1940, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to ——— 19—, and that I last saw h— alive on ——— 19—,

Immediate cause of death — DURATION

Still Birth 5 mos

Due to No Doctor present

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE J J Murphy M D or other

Address Annapolis Md Date signed 3 11 40

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore (8)

CERTIFICATE OF DEATH

02719

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Ca

City or town St Margarets

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Aa

City or town Rural Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. St Margarets

(If rural, give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Girl Denson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	CR	S

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 10 40

8. AGE: Years | Months | Days | If less than one day ... hrs. ... min.

Stillborn

9. Birthplace St Margarets

(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Ellis Denson

13. Birthplace Aa

MOTHER 14. Maiden name Mary Denson

15. Birthplace Aa

16. Informant Lydia Porter

Address Annapolis

17. (Burial, cremation, or removal. Which?) Date thereof 3 11 40 (month) (day) (year)

Cemetery or crematory

Location St Margarets

18. Funeral director Leo Denson Grandfather

Address St Margarets

19. 3 11 19 40 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 10 19 40, at 3 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ..., and that I last saw h...elive on ... 19 ...

Immediate cause of death	DURATION
Still Birth	
Due to 5 mos	
Due to No Doctor present	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J J Murphy by Mrs Regester M. D. or other

Address Annapolis Md Date signed 3 11 40

RECEIVED
APR 5 1940
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (186-a) Reg. Dist. No. 23

CERTIFICATE OF DEATH

02720

1. PLACE OF DEATH:
(a) County A. A.
(b) City or town Potapsco Pk. Brooklyn Pk. (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town Potapsco Pk. Brooklyn Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Nanie Herdon

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William Herdon

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 1882

8. **AGE:** Years 57 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual occupation at Home

11. Industry or business

FATHER 12. Name Rand Overaly

13. Birthplace Va

MOTHER 14. Maiden Name Lizzie Williams

15. Birthplace Va

16 (a) Informant Mary Cowley

(b) Address Potapsco Pk Brookly md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 31 1940 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary

Location a. a. co

18 (a) Funeral director Joseph A. Lively

(b) Address 409 A Mount St Baltimore maryland

19 (a) 29 March 1940 (Date rec'd by registrar) Caldwell Woodruff Registrar

MEDICAL CERTIFICATION

20. Date of death Mar. 28 1940, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1939, to Mar. 28 1940, and that I last saw him alive on March 27 1940.

Immediate cause of death	Duration
Cardio Vascular disease	Dec. 1939
Due to Broken Hip; due to accidental fall in Rest Home, August	Aug. 22-1939
Due to 22nd, 1939. cured	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence August 22nd, 1939
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas L Ball Jr MD (M. D. or other)

Address Linthicum Date signed 3-28-1940

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D) b

02721

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 mos. 8 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Dorchester Co.

City or town: Cambridge Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 210 Pine Street

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: JOSHUA P. HICKS

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE: Years: 69? Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: General

FATHER — 12. Name: Thomas Hicks, dead

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lizzie Moore, dead

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 1940 (month) (day) (year)

Cemetery or crematory: Old Field Cemetery

Location: Church Creek, Md.

18. Funeral director: Louis A. Baynaum

Address: 201 Washington St, Cambridge, Md.

19. Mar 30 1940 (Date rec'd by registrar) E. F. Hoyer Registrar

DL

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29th 1940, at 11:30 M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 21st 1939, to March 29 1940, and that I last saw him alive on March 29th 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions: Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: -----

Of autopsy: ------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 3/29/40

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02722

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A.A.

City or town Rural Near Davidsonville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 31 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Davidsonville, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Joseph T. Hittle

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Alouisa Hittle

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 12 1871

8. AGE: Years	Months	Days	If less than one day
68	6	6	____ hrs. ____ min.

9. Birthplace Austra Hungara
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Alouisa Hittle
Address Davidsonville Md.

17. Burial Date thereof Mar 18 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Marys

Location Annapolis, Md.

18. Funeral director B L Hopping

Address Annapolis, Md.

19. 3-18-40 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 14 1940, at 10pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 7 1940, to Mar. 14 1940, and that I last saw him alive on Mar. 14 1940

Immediate cause of death	DURATION
Arteriosclerotic heart disease	?
Congestive failure	7 days
Due to	
Due to	
Other conditions Pulmonary tuberculosis	4-5 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? W. F.

23. SIGNATURE W. F. Fidler M. D. or other

Address Davidsonville Md. Date signed 3-16-40

RECEIVED
APR 5 1949
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02723

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 23

Village or City Marley Park No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Infant of Mr. Mrs Howard W Hodges

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6. DATE OF BIRTH (month, day, and year): Mar 24 1940

7. AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Holland Rd Marley Pk. Glen Burnie

FATHER

13. NAME: Howard W. Hodges

14. BIRTHPLACE (city or town) (State or country): Rock Hall Md

MOTHER

15. MAIDEN NAME: Ruth J Milke

16. BIRTHPLACE (city or town) (State or country): Balto Md.

17. INFORMANT: Howard W. Hodges. (Address) Marley Pk

18. BURIAL, CREMATION, OR REMOVAL

Place Western Cemetery Date 3-26, 1940

19. UNDERTAKER: Ambrose, Inc. (Address) 1017 W. Cross St.

20. FILED March 26, 1940 Mrs De Alba Dep Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 24 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from March 24, 1940, to March 24, 1940

I last saw her on March 24, 1940; death is said to have occurred on the date stated above, at 11 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Still Born

Date of onset

Other Contributory Causes of Importance:

Name of operation: None Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) R. L. Campbell M. D.

(Address) 1644 Hanover St

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED APR 3 1940 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

02724

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Eastport Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Eastport (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Barbra Jean Holidayoke

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28th 1940

8. AGE:

Years	Months	Days	If less than one day
		3	hrs. min.

9. Birthplace Annapolis Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Laurence Holidayoke

13. Birthplace Eastport Q A Co Md.

MOTHER 14. Maiden name Mary Jeren

15. Birthplace New York

16. Informant Laurence Holidayoke

Address Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1st 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John W. Taylor

Address Annapolis Md.

19. April 1st 1940 (Date rec'd by registrar) J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31st 1940 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1940, to March 31 1940, and that I last saw her alive on March 31 1940.

	DURATION
Immediate cause of death Congenital Jaundice & Neo Born Atalectasis	2
Due to Myocardial caste.	2
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jerry C Bond M. D. or other

Address Annpolis Date signed 3-31-

RECEIVED
APR 5 1940
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

02725

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A 15

1. PLACE OF DEATH:
County: Anne Arundel Co
City or town: Annapolis, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Annapolis - Emergency Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 mo 2/3/40 to 3/17/40
Stay in this community (yrs., or mos., or days): 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Annapolis Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 54 Cornhill St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Margaret Louise Holland

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F.	C	Single

6 (b) Name of husband or wife: Single

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 20, 1921

8. AGE: Years: 18 Months: 7 Days: 26 If less than one day: ____ hrs. ____ min.

9. Birthplace: Shadyside - A.A. Co. Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Henry Holland
13. Birthplace: Shadyside - A.A. Co. Md

MOTHER
14. Maiden name: Gladys Brown
15. Birthplace: Charleston - A.A. Co. Md.

16. Informant: Gladys Holland
Address: Shadyside - Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) March 20, 1940

Cemetery or crematory: St. Paul Cemetery

Location: Shadyside - Md

18. Funeral director: J. D. Solomon

Address: Annapolis Md

19. Mar. 20th 1940 (Date rec'd by registrar) J. H. Mundt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17, 1940, at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3, 1940, to March 17 1940, and that I last saw h alive on March 17 1940.

Immediate cause of death: Peritonitis (Generalized)

DURATION: June Feb. 3, 1940

Due to (or as a consequence of): Ect. Salpenx (rt.) uterine tube

DURATION: June Feb 3, 1940

Due to: True cause of death was Tuberculous per May 31st. by Dr. Stanton Dec. Anderson Jr. Formerly

Other conditions: Miscarriage ewer.

DURATION: Feb. 2, 1940

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Yes

Of autopsy: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?: ____

23. SIGNATURE: Albert L. Anderson Jr. M.D. M. D. or other

Address: Annapolis, Md Date signed: 3/19/40

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02726

CERTIFICATE OF DEATH

(93-d)

WITHIN CORPORATE LIMITS OF

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A.A.

City or town Annapolis,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: #6- Block Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 57 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis, Ward No. 1
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 6 Block
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Holmes

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Married

6 (b) Name of husband or wife William Holmes

6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar 4 1883

8. AGE: Years	Months	Days	If less than one day
57		23	---hrs. ---min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name Edward Watkins

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Louise Boone

MOTHER 15. Birthplace Maryland

16. Informant William Holmes

Address #6- Block Street

17. Burial Date thereof Mar 30 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis, Md.

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19. 3 29 1940 J.H. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27th 1940, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22nd 1940, to March 27th 1940

and that I last saw h--- alive on ---19---

Immediate cause of death	DURATION
Heart failure	
Due to Chronic Myocarditis; decubitus ulcer	5 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings: None

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R.L. Richardson M. D. or other

Address 110 - Clay St. Annapolis Md. Date signed 3/28/40

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93rd

02727

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Anne Arundel

City or town Greenland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Stoney Creek Rd

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Greenland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Stoney Creek Rd
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Grace F. Hoover

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or ~~wife~~ Francis A. Hoover
Stony Creek Rd. 6(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) March 11 - 1892

8. AGE: Years	Months	Days	If less than one day
48 ~~49~~		9	hrs. min.

9. Birthplace Rhode Island
(Town, county, and state)

10. Usual occupation House-wife

11. Industry or business

FATHER
12. Name James Aitken
13. Birthplace Island

MOTHER
14. Maiden name Mary Donahue
15. Birthplace Glasgow, Scotland

16. Informant Francis A. Hoover
Address Stony Creek Rd - Ing.

17. Burial Date thereof March 23/40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Mary's

Location Annapolis Md

18. Funeral director William M Mareck
Address 715 Light St

19. Mar 21 1940 Ida M. Whitson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20 1940, at 2 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 10 1934, to March 20 1940, and that I last saw her alive on March 20 1940.

Immediate cause of death	DURATION
Acute Cardiac Decompensation with Pulmonary edema	1 day
Due to Hypertensive Cardio-Vascular Disease	
Due to Arteriosclerosis	
Other conditions Hemiplegia	8 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Lubin M.D.
M. D. or other
Address 320 Patapsco Ave Date signed 3/23/40

VS A15 (T) MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 3 1940
BUREAU V. S.

02728

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(122-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 yr.10 mos.11 days

Stay in this community (yrs., or mos., or days): --------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1432 Wall Street,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --------

3. (a) FULL NAME: LURALLEE HOWARD

3. (b) Social Security Number: Unknown

4. Sex: female

5. Color or race: black

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: ------

6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1915

8. AGE: Years: 25 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

8. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: -----

FATHER
12. Name: Bernard Howard
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Jennie (Unknown)
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 4-5-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md.

18. Funeral director: Supt.

Address:

19. Apr 5 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27th 1940, at 5:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16th 1938, to March 27 1940, and that I last saw her alive on March 27th 1940.

Immediate cause of death: Strangulation of Illium (small gut) by adhesions between Omentum and Abdominal wall

Due to: General peritonitis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --------

Of autopsy: -----

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of:

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 3/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02729

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 9 mos. 22 das.

Stay in this community (yrs., or mos., or days): ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 400 Bradley Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: RAYMOND JACKSON

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	married

B (b) Name of husband or wife: Anne Jackson

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1901

8. AGE: Years	Months	Days	If less than one day
39	Unknown		---hrs. ---min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: ---

FATHER 12. Name: Raymond Jackson

13. Birthplace: Georgia

MOTHER 14. Maiden name: Victoria (Unknown)

15. Birthplace: Georgia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 4-5-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt.

Address

19. Apr 5 (Date rec'd by registrar) 1940 E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26th 1940, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31st, 1938 to March 26th 1940, and that I last saw him alive on March 26th 1940.

Immediate cause of death	DURATION
General peralysis of the insane	
Due to	
Due to Lues	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings: ---

Of operations:

Of autopsy: ---

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury: Injured at work? ---

23. SIGNATURE: Chas. F. Ammerman M. D. or other

Address: Crownsville, Maryland Date signed: 3/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
DEPT. OF U. S.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 108

Reg. Dist. No. 21

02730

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Anne Arundel

(b) City or town Green Haven
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Green Haven
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Rosemarie Jensen

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16 1937

8. AGE: Years 2 | Months 7 | Days 23 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Jes. H. Jensen
13. Birthplace Denmark

MOTHER
14. Maiden Name Alice C. Whittaker
15. Birthplace Rockville, Md.

16 (a) Informant Jes Jensen
(b) Address Green Haven

17 (a) burial (Burial, cremation, or removal) (b) Date thereof March 12-40 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Glen Burnie, Md.

18 (a) Funeral director T. Singleton
(b) Address Glen Burnie, Md.

19 (a) 3-10-40 (Date rec'd by registrar) (b) L. A. Breir Registrar

MEDICAL CERTIFICATION

20. Date of death March 10 1940, at 11.55AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1940, to 3-10 1940, and that I last saw him alive on 3-9 1940.

Immediate cause of death	Duration
Lobar pneumonia	7 days
Due to	
Due to	
Other conditions Umbilical hernia	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. A. Breir M.D. (M. D. or other)

Address Pasadena, Md. Date signed 3-10-40

RECEIVED
APR 4 1940
BUREAU V. M.

02731

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (94a)

County Anne Arundel Registration Dist. No. 25

Village or City Brooklyn No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mr. John Kuchar

(a) Residence: No. Matthews Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Christina Kuchar

6. DATE OF BIRTH (month, day, and year): Feb 8, 1878

7. AGE: Years 62 | Months 1 | Days 13 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Laborer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Austria

FATHER

13. NAME: Aloise Kuchar

14. BIRTHPLACE (city or town) (State or country): Austria

MOTHER

15. MAIDEN NAME: Not Known

16. BIRTHPLACE (city or town) (State or country): [illegible]

17. INFORMANT (Address): Christina Kuchar Brooklyn

18. BURIAL, CREMATION, OR REMOVAL

Place: Holy Cross Date: March 25, 1940

19. UNDERTAKER (Address): Frank Cvachalen 1906 Ashland Ave

20. FILED: Mar 21, 1940 Ida M. Whiteman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 21 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from March 20, 1940, to March 21, 1940

I last saw him alive on March 21, 1940; death is said to have occurred on the date stated above, at 7.30 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	3/20/40

Other Contributory Causes of importance:

Name of operation — Date of

What test confirmed diagnosis? Clinical. Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Lawrence M. Serra M. D.

(Address) 1009 Annapolis Blvd.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants and wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

02732

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Ca

City or town Friendship

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Ca

City or town Friendship Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None - None

3. (a) FULL NAME Roland Leitch

3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Era Leitch

6(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept 10 1886

8. AGE: Years 53 Months 6 Days 5 If less than one day ____ hrs. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name C. C. Leitch

13. Birthplace Md.

MOTHER 14. Maiden name Josephine Ward

15. Birthplace Md.

16. Informant Mrs. Roland Leitch

Address Friendship

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 18, 1940 (month) (day) (year)

Cemetery or crematory Friendship

Location Friendship, Md.

18. Funeral director Robert J. Wood

Address Friendship

19. 3/16 1940 (Date rec'd by registrar) W. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1940, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1939, to 3/15 1940, and that I last saw him alive on 3/15/40 1940.

Immediate cause of death Acute

Bright Disease — DURATION 3 mo

Hypertension — 7 mo

Due to Cerebral Hemorrhage — 5 da

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hugh W Ward M. D. or other

Address Ormond Md Date signed 3/15/40

VS A15 (T) (I) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

02733

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or insf. (yrs., or mos., or days) 2 days.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.

City or town Annapolis Md. Ward No. 3

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 9 Brewer Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Herman McNamara

3. (b) Social Security Number —

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hennie May McNamara

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3d 1867

8. AGE: Years 73 Months Days 20 If less than one day hrs. min.

9. Birthplace Dorchester Co. Md.

(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

FATHER 12. Name Jerome McNamara

13. Birthplace Dorchester Co. Md.

MOTHER 14. Maiden name Cornelia Mister

15. Birthplace Dorchester Co Md

16. Informant Orville W. McNamara

Address Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 26th 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John M. Taylor

Address Annapolis Md.

19. 3 26 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1940, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1940, to March 23 1940, and that I last saw him alive on March 23 1940.

Immediate cause of death Edema of lungs acute — DURATION 3-23

Due to Broken Back - 4 — 3-22

Due to vertebra

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Accident Date of 3.22.40

Where did injury occur? West St. Annapolis Va Co Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) public place

Means of injury fell from ladder Injured at work? yes

23. SIGNATURE George S Basil M. D. or other

Address Annapolis Md Date signed 3-25-40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 1 1940
BUREAU V. S.

02734

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 9 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1909 Etting Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: PHILIP MONTAGUE

3. (b) Social Security Number: Unknown

4. Sex: Male

5. Color or race: black

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dora Montague

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years: 60 Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: -----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-28-40 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: H.A. ~~Baltimore~~ Gaddis Co

18. Funeral director: Archibald A. Gaddis

Address: 2101 McCulloh St. Baltimore

19. March 25 1940 (Date rec'd by registrar) E. F. Joyce DL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24th 1940, at 7:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15th 1940, to Mar. 24 1940, and that I last saw him alive on Mar. 24th 1940.

Immediate cause of death: Exhaustion due to manic depressive insanity

Due to:

Due to:

Other conditions: Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ----------

Of autopsy: ------

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 3/24/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1948
BUREAU V. S.

02735

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (83a)

County: Anne Arundel — Registration Dist. No. 20

Village or City: South River — No. County Home St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Morris Muzzey — Social Security No: 217-03-3841

(a) Residence: No. County Home St., Ward. (Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year): Dec. 16, 1874

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
76	3	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country): New York

FATHER

13. NAME ✓

14. BIRTHPLACE (city or town) (State or country) ✓

MOTHER

15. MAIDEN NAME ✓

16. BIRTHPLACE (city or town) (State or country) ✓

17. INFORMANT (Address): Mr. Tucker Co. Home.

18. BURIAL, CREMATION, OR REMOVAL Place: Co Home Date: Mar 11, 1940

19. UNDERTAKER (Address): Jas. T. Cox Annapolis

20. FILED: March 11, 1940 Carrie J. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Mar. (Month) 10 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1939, to Mar. 10, 1940

I last saw him alive on Mar. 9, 1940; death is said to have occurred on the date stated above, at 6:00 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage	3-7-40
Gen. arteriosclerosis	?

Other Contributory Causes of importance:

Name of operation: none — Date of

What test confirmed diagnosis? none — Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W. F. Fidler M.D.

(Address) Davidsonville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

(T)

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

92736

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Jones Station A.A.Co. Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address (hospital, or institution):

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Jones Station Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Anny Wernty Ogle

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maurice Ogle

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 28th 1884

8. AGE: Years: 56 | Months: | Days: 2 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Pottsville Penn
(Town, county, and state)

10. Usual occupation: U. S. Naval Academy

11. Industry or business: Preparatory School - Teacher

FATHER
12. Name: Charles E. Wernty
13. Birthplace: Penn

MOTHER
14. Maiden name: Emma Bedford
15. Birthplace: Penn

16. Informant: Maurice Ogle
Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 3rd 1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: John M. Sayler

Address: Annapolis Md.

19. 3-2 1940 (Date rec'd by registrar)

J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 1 1940, at 3.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14 1940 to Mar. 1 1940, and that I last saw her alive on Mar. 1 1940

Immediate cause of death	DURATION
Hemiplegia - Cerebral hemorrhage	15 days
Due to Arterial hypertension	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M.D.
M. D. or other

Address Annapolis Md Date signed 3/1/40

RECEIVED
APR 6 1940
BUREAU V. S.

02737

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93 ab)

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County aa

City or town Deales

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County aa

City or town Deales Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Miss Lillian Owen

3. (b) Social Security Number

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1889

8. AGE: Years 51 Months 1 Days 0 If less than one day hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Frank Dress

13. Birthplace Baltimore

MOTHER 14. Maiden name Abbie Hudson

15. Birthplace Baltimore

16. Informant Mrs. Russell Hardesty

Address Bay Ridge Road Easport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 6, 1940 (month) (day) (year)

Cemetery or crematory Parkwood Cemetery

Location Taylor Ave, Baltimore Md.

18. Funeral director T. G. Hardesty & Son

Address Galesville, Md.

19. March 5 1940 (Date rec'd by registrar) J B Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/40 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1940, to Feb 25 1940, and that I last saw her alive on Feb 25 1940.

Immediate cause of death Acute myocarditis at 2 P.M. Chronic Myocarditis

DURATION 5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hugh W Ward M. D. or other

Address Owings Md Date signed 3/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (524)

CERTIFICATE OF DEATH

02738

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Drury
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Drury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas Owens

3. (b) Social Security Number None.

4. Sex: Male
5. Color or race: Col.
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rosie Owens
6(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Jan 14 1881 11/16/66
8. AGE: Years 73 59 | Months 4 | Days 13 | If less than one day hrs. min.
9. Birthplace: Bristol A. A. Co Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Wm Owens
13. Birthplace: Md
MOTHER 14. Maiden name: Mary Young
15. Birthplace: Md.
16. Informant: Rosie Owens
Address: Drury P.O. Md.
17. (Burial, ~~cremation, or removal~~. Which?) Date thereof April 1, 1940 (month) (day) (year)
Cemetery ~~or crematory~~ Walkers Chapel Cem.
Location Drury Md.
18. Funeral director: F. G. Stansbury & Son
Address Galesville Md.
19. March 30 1940 W R Clayton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1940, at 8.45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to March 29 1940
and that I last saw h- alive on March 29 1940

	DURATION
Immediate cause of death: Cancer of Bladder	1 Year
Due to	
Due to	
Other conditions: Hemorrhage	2 days

(Include pregnancy within 3 months of death)
Major findings: Of operations: Curretted about one year ago for Cancer of Prostate
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Remedy Sasser M. D. or other
Address Upper Marlboro Date signed 3/30/40

CHANGE OF BIRTHDATE and computation of age accordingly:
letter October 2, 1940 under Dr.Sasscer. - L.

RECEIVED
APR 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

02739

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lothian
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Lothian Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Stell Bord Parker

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 27 - 1940

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Walter Parker
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Johnson
15. Birthplace: Maryland

16. Informant: Walter Parker
Address: Lothian Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/40 (month) (day) (year)
Cemetery or crematory: Adams Chapel
Location: Lothian

18. Funeral director: Walter Parker
Address: Lothian Md

19. 3/28 1940 (Date rec'd by registrar) W. K. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/27 1940, at Noon M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death: Stell Bord — DURATION

Due to: no Physician in attendance

Due to: Only Midwife

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W. K. Clayton M. D. or other
Address: Lothian Md Date signed 3/28/40

RECEIVED
APR 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

02740

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 12 Fleet St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Ennalgency Hospital Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Penn

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fem	Colored	Married

6 (b) Name of husband or wife Joseph W. Penn
6(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 27 1902

8. AGE: Years 38 | Months 37 | Days 18 | If less than one day ____ hrs. ____ min.

9. Birthplace Cape May N. J.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Benjamin Abelpiah
13. Birthplace East Indies

MOTHER 14. Maiden name Daisy Parker
15. Birthplace A. A.

16. Informant Jacob Wardell Henson
Address Shadmoor

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 22 1940 (month) (day) (year)
Cemetery or crematory Brewer Hall
Location Annapolis

18. Funeral director J. B. Johnson
Address Annapolis

19. 3-22 1940 (Date rec'd by registrar) J. M. Mudd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1940, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1940, to March 19 1940, and that I last saw h alive on March 14 1940.

Immediate cause of death: Arteriosclerotic Cardio-Vascular disease — DURATION: Since 1939

Due to

Due to

Other conditions: Chronic Interstitial Nephritis — 1939

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Gilbert L. Anderson M.D.
M. D. or other
Address Annapolis, Md. Date signed 3/22/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAR 23 1940
BUREAU V. S.

02741

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: near Whitney's Landing (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Juniper's Hole Road

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Whitney's Landing, Severna Park, P.O. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Juniper's Hole Road (If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Infant James W. Pettigrew

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	negro	S

6 (b) Name of husband or wife: —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 17 1940

8. AGE: Years | Months | Days: 2 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Whitney's Landing, Severna Pk. P.O. (Town, county, and state)

10. Usual occupation: —

11. Industry or business:

FATHER 12. Name: Robert Pettigrew

13. Birthplace: Balto. Md

MOTHER 14. Maiden name: Ethel Clopton

15. Birthplace: Severna Park, Md

16. Informant: Rubin Clopton

Address: Severna Park, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-20-40 (month) (day) (year)

Cemetery or crematory:

Location: Robert Pettigrew

18. Funeral director:

Address: P.O. Severna Park

19. 3-19 1940 (Date rec'd by registrar) L. A. Brew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1940, at 10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem examination and that I last saw h____ alive on ____ 19____

Immediate cause of death: Congenital Debility (Pre-mature, 8 mos)

Due to: Convulsions

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

DURATION: 2 days; 1 day

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: John M. Claffy, Deputy Medical Examiner, M. D. or other

Address: Annapolis Md Date signed: 3/20/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02742

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Anne Arundel

City or town Deale

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 19 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Deale Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Preston Blane Phipps

3. (b) Social Security Number

4. Sex M.

5. Color or race W.

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2. 1930

8. AGE: Years 19 Months 4 Days 0 If less than one day hrs. min.

9. Birthplace Chuckton Md (Town, county, and state)

10. Usual occupation Well Drilling

11. Industry or business

FATHER 12. Name Guy B. Phipps

13. Birthplace Chuckton

MOTHER 14. Maiden name Della Rogers

15. Birthplace Deale Md

16. Informant Guy B. Phipps

Address Deale

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 5. 1940 (month) (day) (year)

Cemetery or crematory Mt. Zion Cem.

Location Lothian Md

16. Funeral director T. A. Hardisty & Son

Address Galesville Md.

19. Mar 5. 1940 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 29, 1940, to March 2 1940, and that I last saw him alive on Feb 29 1940.

Immediate cause of death Tuberculosis of 1 Lungs

Due to 2 Peritoneum

3 Gastro Intestinal Tract

Due to including throat

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION Don't know

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. B. West M. D. or other

Address Lothian Md Date signed 3/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 16 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

02743

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A.A.

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 165 West Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 10 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Annapolis, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 165 West Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Walter E. Phipps

3. (b) Social Security Number: 214-12-9366

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude E. Phipps

6(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Aug 2 1878

8. AGE: Years: 61 Months: 7 Days: 3 If less than one day: hrs. min.

9. Birthplace: A.A. County
(Town, county, and state)

10. Usual occupation: Night Watchman

11. Industry or business:

FATHER
12. Name: Walter E. Phipps
13. Birthplace: A.A. County

MOTHER
14. Maiden name: Nettie Marshall
15. Birthplace: A.A. County

16. Informant: Maude E. Phipps
Address: 165 West Street Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 8 1940 (month) (day) (year)

Cemetery or crematory: All Hallows

Location: Birdsville Maryland

18. Funeral director: B.L. Hopping
Address: Annapolis, Maryland

19. 3-8 (Date rec'd by registrar) 19 J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1940, at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1939, to March 5, 1940, and that I last saw him alive on March 5, 1940.

Immediate cause of death	DURATION
Cerebral apoplexy	1 hr.
Due to Hypertension	1 yr.
Due to Arteriosclerotic Cardio-Vascular disease	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other
Address: Annapolis, Md. Date signed: 3/6/40

VS A15 (T) (I) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02744

(53)

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 20

Village or City ..... No. County Home St., ... Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME John Puckett If U. S. Veteran, specify WAR .....

(a) Residence: No. County Home St., ... Ward. .....

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6. DATE OF BIRTH (month, day, and year) Dec. 3, 1862

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	3	7	

OCCUPATION

8. Trade, profession, or perticular kind of work done, as SPINNER, SAWYER, BODKKEEPER, etc. not known

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked et this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) not known (State or country) Maryland

FATHER

13. NAME not known

14. BIRTHPLACE (city or town) — (State or country)

MOTHER

15. MAIDEN NAME not known

16. BIRTHPLACE (city or town) — (State or country)

17. INFORMANT Mrs. Tucker (Address) County Home

18. BURIAL, CREMATION, OR REMOVAL

Place Co Home Date Mar 18 1940

19. UNDERTAKER Jas. T. Cox (Address) Annapolis

20. FILED March 12 1940 Carrie J. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Mar. (Month) 10 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1939, to Mar. 10, 1940

I last saw him alive on Mar. 9, 1940; death is said to have occurred on the date stated above, at 6:30 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Epithelioma of face with multiple metastases about	1935

Other Contributory Causes of importance:

Generalized arteriosclerosis	?
Arteriosclerotic heart disease	?

Name of operation none Date of —

Whet test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury .....

Nature of Injury .....

24. Wes disease or injury in eny way related to occupation of deceased? no

If so, specify .....

(Signed) W. F. Fidler M. D.

(Address) Davidsonville Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

(1)

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED APR 16 1928 BUREAU V.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

02745

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131-B

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Severna Park.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 4 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Anne Arundel.

City or town: Severna Park. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: —

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no —

3. (a) FULL NAME: Thomas Rexon.

3. (b) Social Security Number:

4. Sex: Male.

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Elizabeth Keil.

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 26, 1866

8. AGE: Years: 74 Months: 1 Days: 1 If less than one day: hrs. min.

9. Birthplace: Philadelphia. Pa.

(Town, county, and state)

10. Usual occupation: Dairy Farmer.

11. Industry or business: Ice Cream & Milk

FATHER

12. Name: Thomas Rexon.

13. Birthplace: England.

MOTHER

14. Maiden name: Martha Brown.

15. Birthplace: England.

16. Informant: Mrs. Eva Mallack.

Address: Severna Park. Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: April 3. 1940. (month) (day) (year)

Cemetery or crematory: Colestown Cmt

Location: Haddonfield. N. J.

18. Funeral director: J. J. McCully

Address: 130 E. Fort Ave.

19. March 30 1940 (Date rec'd by registrar) M. R. DeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29, 1940, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940, to March 29 1940, and that I last saw him alive on Mar 27. 1940.

Immediate cause of death: Hemorrhage in the Brain — DURATION: Immediate.

Due to: Arterio-Sclerosis — 2 yrs

Due to: Chronic Interstitial Nephritis — 2 yrs

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings: —

Of operations:

Of autopsy: —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James S. Bellingolo M.D. M. D. or other

Address: Glen Burnie. Md. Date signed: Mar 30, 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02746

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (83a)

County Anne Arundel Registration Dist. No. 21

Village or City Annapolis No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME John H. Rodgers If U. S. Veteran, specify WAR

(a) Residence: No. Clunelton St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Laura E. Rodgers

6. DATE OF BIRTH (month, day, end year) Aug 14, 1870

7. AGE	Yeers	Months	Deys	If LESS then 1 dey, hrs. or min.
	69	7	2	

OCCUPATION

8. Trede, profession, or particuler kind of work done, es SPINNER, SAWYER, BOOKKEEPER, etc. Merchant

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. General Merchandise

10. Dete deceased last worked at this occupetion (month end year)

11. Totel time (years) spent in this occupetion

12. BIRTHPLACE (city or town) (Stete or country) Town Pt. Fair Haven Md.

FATHER

13. NAME James W. Rodgers

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Mary E. Phipps

16. BIRTHPLACE (city or town) (State or country) Deale Md.

17. INFORMANT (Address) James C. Rodgers Clunelton

18. BURIAL, CREMATION, OR REMOVAL
Place Smithers Cemetery Date 3/18, 1940

19. UNDERTAKER (Address) T. A. Hardesty & Son, Galesville Md.

20. FILED 3-17, 1940 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 16, (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from February, 1940, to March 16, 1940

I last saw h-im alive on March 15, 1940; death is said to heve occurred on the dete stated above, et 1 A. m.

The **PRINCIPAL CAUSE OF DEATH** and related ceuses of importance were es follows:

	Date of onset
Cerebral arteriosclerosis	15 yrs. ago
Cerebral hemorrhage	1 yr. ago
Cerebral hemorrhage	2½ wks. ago

Other Contributory Causes of importence:

Prostatectomy	8 yrs. ago

Name of operation Date of

What test confirmed diegnosis? none Was there en autopsy? no

23. If deeth wes due to externel ceuses (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Neture of injury

24. Was diseese or injury in any wey releted to occupation of deceased? no

If so, specify

(Signed) Samuel M. Reichel M. D.

(Address) 1 Munroe Ct. Annapolis, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED
APR 5 1940
M.A.I. U. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

02747

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(122C)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospt.

Stay in hospital or inst. (yrs., or mos., or days): 15 days.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md. Ward No. 3 (If outside city or town limits, write RURAL NEAR and give town)

Street No. 1 Cathereal St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Vasiliki Roussos

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

8 (b) Name of husband or wife: George Roussos.

8(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): Aug 14th 1913

8. AGE: Years 26 Months 7 Days 6 If less than one day ___ hrs. ___ min.

9. Birthplace: Greece (Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business:

FATHER 12. Name: John D. Skordas

13. Birthplace: Greece

MOTHER 14. Maiden name: Penelope Keramidas

15. Birthplace: Greece

16. Informant: George Roussos

Address: Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 22-1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. Mar. 22nd 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-20 1940, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-5- 1940, to 3-20 1940, and that I last saw her alive on 3-20 1940.

Immediate cause of death: Acute Myocarditis & Myocardial Insufficiency — DURATION: 3-20

Due to: General peritonitis — 3-19

Due to: Intestinal obstruction: not due to cancer; due to adhesions following operation.

Other conditions: Duration: ten days. C.W.G.R. (Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: Same

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C. Basil M. D. or other

Address: Annapolis Md Date signed: 3-20-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 5 1919
BUREAU V. S.

02748

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

WITHIN CORPORATE LIMITS OF

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospt.

Stay in hospital or inst. (yrs., or mos., or days) 3

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md. Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 47 Amos Garrett Blvd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Walter H. Russell

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jany 9th 1877

8. AGE: Years 63 | Months 2 | Days 13 | If less than one day ____ hrs. ____ min.

9. Birthplace Macomb Ill.
(Town, county, and state)

10. Usual occupation Linotype operator

11. Industry or business

FATHER
12. Name John B. Russell
13. Birthplace Kt.

MOTHER
14. Maiden name Henrietta Scott
15. Birthplace Penn.

16. Informant Dean Russell
Address Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Mar 23rd 1940
(month) (day) (year)

Cemetery or crematory

Location Macomb Ill

18. Funeral director John M. Taylor
Address Annapolis Md.

19. 3 2 3 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1940, at 12.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 29 1940, to March 22 1940, and that I last saw him alive on March 22 1940.

Immediate cause of death: Coronary Thrombosis — DURATION: Immediate

Due to

Due to

Other conditions: Had 2 previous attacks in past 2 yrs.
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE Maurice F. Klawans Md
M. D. or other

Address 31 Southgate Av Date signed 3/22/40

VS A15 (T) MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 6 1940
BUREAU V. S.

02749

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-8)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Rural. Weems Creek. Near Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 Year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Weems Creek, Near Annapolis, Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret C. Sewell

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John W. Sewell

6(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) May 1 1866

8. AGE:

Years	Months	Days	If less than one day
73	8	1	hrs. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Luke Burns
13. Birthplace Ireland

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant John W. Sewell

Address Weems Creek Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 5 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis, Maryland.

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19. 3-5 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1940, at 6 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1940, to March 2 1940, and that I last saw her alive on March 2 1940.

Immediate cause of death Uremia & Gastric Hemorrhage

Due to Chronic Myocarditis & Valvular Heart Disease

Due to Chronic Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 3 days

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walton H Hopkins Md M. D. or other

Address Annapolis Md Date signed 3/4/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

02750

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 21 days
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Mt. Victoria Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: JAMES SMALLWOOD

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE: Years	Months	Days	If less than one day
66	Unknown		____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ------

FATHER
12. Name: Henson Smallwood
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza Jane Linkfield
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 4-5-40 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville

18. Funeral director: Supt.
Address

19. Apr. 5 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28th 1940, at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7th 1940 to March 28 1940, and that I last saw him alive on March 28th 1940

Immediate cause of death: Broncho pneumonia — DURATION: 1 da.

Due to: ----- DURATION: -----

Due to: ----- DURATION: -----

Other conditions: Chronic myocarditis — DURATION: -----

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ------
Of autopsy: -----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: Injured at work? -----

23. SIGNATURE: Clark L. Thompson M. D. or other
Address: Crownsville, Maryland Date signed: 3/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02751

WITHIN CORPORATE LIMITS OF

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Ward No. 4
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 87 Northwest
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henry Smith
3. (b) Social Security Number None

4. Sex Male
5. Color or race Col.
6. (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 1 1860
8. AGE: Years 80 Months 3 Days 27 If less than one day hrs. min.
9. Birthplace Annapolis Anne Arundel Co. Md.
(Town, county, and state)
10. Usual occupation laborer
11. Industry or business
FATHER 12. Name John Smith
13. Birthplace Anne Arundel Co.
MOTHER 14. Maiden name Susan Tucker
15. Birthplace unknown
16. Informant Estelle Allsup
Address 87 Northwest st Annapolis Md
17. Burial Date thereof Mar. 7 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Brewer Hill Cemetery
Location On Washington rd. outside town
18. Funeral director Chas. H. Alexander
Address 43, 45 Northwest st. Annapolis Md.
19. 3-6th 1940 J J Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1940, at 10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27 1940, to Mar 4 1940, and that I last saw him alive on March 3 1940.

Immediate cause of death — DURATION
Congestive Heart Failure — Feb 1940
Due to
Chr. Myocarditis
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice F. Klawans, MD
M. D. or other
Address 31 Smith gate W Date signed 3/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02752

1. PLACE OF DEATH (61)

County: Anne Arundel — Registration Dist. No. 21

Village or City: Riviera Beach — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME William H Stevens — If U. S. Veteran, specify WAR ____

(a) Residence: No. Riviera Beach Co. St., Co. Ward. ____ (Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widower.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence V. Stevens

6. DATE OF BIRTH (month, day, and year): March 27th 1863

7. AGE: Years 76 — Months 11 — Days 20 — If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Retired Police
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Sargeant
10. Date deceased last worked at this occupation (month and year): ____
11. Total time (years) spent in this occupation: 45 yrs.

4793

12. BIRTHPLACE (city or town) (State or country): Pa.

FATHER

13. NAME: Unknown
14. BIRTHPLACE (city or town) (State or country): Unknown

MOTHER

15. MAIDEN NAME: Unknown
16. BIRTHPLACE (city or town) (State or country): Unknown

17. INFORMANT (Address): William Stevens, Riviera Beach

18. BURIAL, CREMATION, OR REMOVAL — Place: Cathedral Cem. Date: March 20th, 1940

19. UNDERTAKER (Address): Charles F. Dill, 1501 E Fort Ave.

20. FILED: March 18, 1940 — M S De Alba, Dep. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 17th (Day), 193 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 2/16/40, 19__, to 3/17/40, 19__

I last saw him alive on 3/16/40, 19__; death is said to have occurred on the date stated above, at 1 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Diabetes Mellitus	[illegible]
Chronic Endocarditis	
Arterio Sclerosis	

Other Contributory Causes of Importance:

Pulmonary Edema	1 day
Cardiac Failure	

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19__

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) Walter [illegible] M. D.

(Address) [illegible] Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

(I) (T)

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02753

CERTIFICATE OF DEATH

(121)

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 6 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Wardour Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Wardour on the severn

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Meta Melville Stockwell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Herbert Grant Stockwell

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 30th 1875

8. AGE:

Years	Months	Days	If less than one day
64	11	9	____ hrs. ____ min.

9. Birthplace: Sharon Hill Penn.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: George W. Mabelle

13. Birthplace: New York N. Y.

MOTHER — 14. Maiden name: Henrietta B Walthron

15. Birthplace: New York State

16. Informant: Herbert Stockwell

Address: Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 11th 1940 (month) (day) (year)

Cemetery or crematory: St Annis

Location: Annapolis Md.

18. Funeral director: John W. Sayler

Address: Annapolis Md.

19. Mar 11th 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1940, at 7:43 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1940 to March 9 1940, and that I last saw h[illegible] alive on March 9 1940.

Immediate cause of death: Rupture Of Aortic Ventricular Aneurism — DURATION: 3-3-40

Due to:

Due to:

Other conditions: Valvular Heart Disease & Chronic Hypertension

(Include pregnancy within 3 months of death)

Major findings:

Operations: Ruptured Aortic Aneurism

Autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Walton H. Hopkins M D

M. D. or other

Address: Annapolis Md — Date signed 3-10-40

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02754

2411 N. Charles St., Baltimore (928)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 26 Chesapeake Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mathilde C. Swenson

3. (b) Social Security Number

4. Sex	5. Color or Race	6. (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife Carl L. Swenson
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13 - 1881

8. AGE: Years	Months	Days	If less than one day
58	7	11	hrs. min.

9. Birthplace Randers. Denmark
(Town, county, and state)
10. Usual occupation Home work
11. Industry or business
FATHER 12. Name Boge Christenson
13. Birthplace Denmark
MOTHER 14. Maiden name Nielsen
15. Birthplace Nielsen
16. Informant Helmar Schmidt
Address Eastport a.a Co md
17. cremation (Burial, cremation, or removal. Which?) Date thereof Mar. 27-1940 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Washington D.C.
18. Funeral director John M. Taylor
Address Annapolis md
19. 3 26 (Date rec'd by registrar) 19 40 J M Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 40, at 7.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept - 19 39, to March 24 19 40, and that I last saw h- alive on March 24 19 40.

Immediate cause of death	DURATION
Arteriosclerotic C.V.R. disease	
Left Ventricular hypertrophy	
Due to Mitral stenosis	
Mitral Insufficiency.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E Eberhart M.D.
M. D. or other
Address Eastport, Md Date signed 3-24-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

02755

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS.A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: A. A. Co. Jail on Calvert St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No. 4

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Calvert St. Co Jail

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George Washington Taylor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary Taylor

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 2nd 1867

8. AGE:

Years	Months	Days	If less than one day
72	4	8	hrs. min.

9. Birthplace: a. A. Co Md (Town, county, and state)

10. Usual occupation: Warden of A. A. Co Jail

11. Industry or business:

FATHER

12. Name: George W. Taylor

13. Birthplace: A. A. Co Md

MOTHER

14. Maiden name: Mary Ann Tucker

15. Birthplace: Unknown

16. Informant: Mary Taylor

Address: Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 13 1940 (month) (day) (year)

Cemetery or crematory: Memorial

Location: Mayo A. A. Co Md

18. Funeral director: John W. Taylor

Address: Annapolis Md.

19. 3-12-40 (Date rec'd by registrar) J. M. Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-9 1940, at 10/30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to March 9 1940 and that I last saw him alive on March 9 1940.

Immediate cause of death: Myocarditis & Myocardial Degeneration

Due to: Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

Unknown

Unknown

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George C Bauer M. D. or other

Address: Annapolis Date signed 3-11-40

RECEIVED
APR 5 1940
BUREAU V. S.

02756

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A.

City or town Annapolis (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 35 Paca st.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A. A.

City or town Annapolis Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 35 Paca st. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Catherine Tytus

3. (b) Social Security Number none

4. Sex fem

5. Color or race colo

6. (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Charles Tytus

6(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 10 1871

8. AGE: Years 68 Months 6 Days 23 If less than one day ___ hrs. ___ min.

9. Birthplace A. A. (Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name Henry Wright

13. Birthplace A. A.

MOTHER 14. Maiden name Hamma Wright

15. Birthplace A. A.

16. Informant Hannah Porter

Address Arnold

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 7 1940 (month) (day) (year)

Cemetery or crematory Mt Calvary

Location Arnold, A. A. Co.

18. Funeral director J. B. Johnson

Address Annapolis

19. 3 7 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3 1940, at 3 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26th 1940, to March 3rd 1940, and that I last saw her alive on March 3rd 1940.

Immediate cause of death Cerebral Apoplexy

Due to Chronic Nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 7 days. One year

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Richardson M. D. or other

Address 100 Clay St. Annapolis Date signed 3/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-D)

Reg. Dist. No. 23

02757

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County A. A.

(b) City or town ~~Woodlawn~~ Garland Pk.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 10 yr.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County A. A.

(c) City or town Garland Pk. (Ferndale)
(If outside city or town limits, write RURAL and give town)

(d) Street No. Elm.
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Elizabeth ~~Virginia~~ Matilda Wheeler Wade

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Wm H. Wade

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1864

8. **AGE:** Years 75 | Months 4 | Days 6 | If less than one day _____ hr. _____ min.

9. Birthplace A. A. Co.
(Town, county, and state)

10. Usual occupation H.W.

11. Industry or business None

FATHER
12. Name William Wheeler
13. Birthplace A A Co Md

MOTHER
14. Maiden Name Eliza Stickcomb
15. Birthplace Maryland

16 (a) Informant Lawrence Wade
(b) Address Elm Ave (A A Co)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23/40 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location ~~Bulto Co~~ H Wa

18 (a) Funeral director William Cook
(b) Address 1217 St Paul St

19 (a) March 21 (Date rec'd by registrar) (b) Matilda R. DeAlba Dep. Registrar

MEDICAL CERTIFICATION

20. Date of death March 20 1940, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1938, to March 20 1940, and that I last saw him alive on March 19 1940.

Immediate cause of death	Duration
Cardio-vascular disease	1938
Angina	3-20-40
Due to	
Due to Arterio Sclerosis	1930
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas. L. Ball Jr MD
M. D. or other

Address Linthicum Date signed 3-20-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

02758

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Elkridge Forest

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Elkridge Forest Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth M. Wagner

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife J. H. Wagner

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16th 1862

8. AGE:

Years	Months	Days	If less than one day
78	0	0	hrs. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Jacob Trimmel

13. Birthplace Germany

MOTHER 14. Maiden name Clara Klinderhoffer

15. Birthplace Germany

16. Informant Mrs. J. Fales Brooks

Address Elkridge Forest R.F.D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 19th 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John M. Taylor

Address Annapolis Md.

19. March 17th 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16th 1940, at 11:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1940 to March 16 1940, and that I last saw h alive on March 13 1940.

Immediate cause of death Exhaustion

Due to Cerebral Hemorrhage

Due to

Other conditions Diabetes Mellitus.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

Not Known

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walton H. Hopkins M. D.

M. D. or other

Address Annapolis Md. Date signed 3/17/40

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4-2)

02759

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1211 Poplar Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: William Frederick Welch

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife: Mary E. Welch

6(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 25th 1874

8. AGE:

Years	Months	Days	If less than one day
66	9	19	____ hrs. ____ min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: Engineer Naval Academy Ret.

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Alton B. Welch
Address: 7 Thompson St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 17th 1940 (month) (day) (year)

Cemetery or crematory: St Annes

Location: Annapolis Md

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. March 16th 1940 (Date rec'd by registrar)

J. H. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15th 1940, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11, 1940 to March 15, 1940 and that I last saw him alive on March 14, 1940.

Immediate cause of death	DURATION
Carcinoma of Stomach with Metastasis to the lungs + liver + other adjacent Organs.	Unknown
Due to	
Due to	
Other conditions Anemia, Myocarditis Chronic.	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. I. Miser M. D.
(M. D. or other)

Address: U.S. Naval Academy Date signed: 3-15-40

Lieut. (MC) U.S. Navy.

RECEIVED
MAR 28 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02760

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md. Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 5 Franklin St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby White

3. (b) Social Security Number

4. Sex m
5. Color or race white
6. (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 18 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name John O. White
13. Birthplace Annapolis Md.

MOTHER
14. Maiden name Helen Caroline Tatt
15. Birthplace Annapolis Md.

16. Informant John O. White
Address Franklin St. Annapolis Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Mar 19th 1940 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18. Funeral director John M. Taylor
Address Annapolis Md.

19. 3-18th 1940 J J Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 18th 1940, at 8:10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death Premature Birth about 4 1/2 to 5 months Developed.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J Oliver Purvis
M. D. or other
Address Annapolis Md. Date signed Mch 18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 15 1940
BUREAU V. S.